EXHIBIT B

IN RE: VIOXX® PRODUCTS LIABILITY LITIGATION	MDL Docket No. 1657
THIS RELATES TO: Civil Action No:	Plaintiff: _____ (name)

PLAINTIFF PROFILE FORM

Other than in Sections I, those questions using the term "You" should refer to the person who used VIOXX®. Please attach as many sheets of paper as necessary to fully answer these questions.

I. CASE INFORMATION

A. Name of person completing this form: _____

B. If you are completing this questionnaire in a representative capacity (e.g., on behalf of the estate of a deceased person or a minor), please complete the following:

1. Social Security Number: _____
2. Maiden Or Other Names Used or By Which You Have Been Known: _____
3. Address: _____
4. State which individual or estate you are representing, and in what capacity you are representing the individual or estate? _____
5. If you were appointed as a representative by a court, state the:

   Court: _____ Date of Appointment: _____
6. What is your relationship to deceased or represented person or person claimed to be injured? _____
7. If you represent a decedent's estate, state the date of death of the decedent and the address of the place where the decedent died: _____

C. Claim Information

1. Are you claiming that you have or may develop bodily injury as a result of taking VIOXX®? Yes_____ No_____ ***If "yes,"***

   a. What is your understanding of the bodily injury you claim resulted from your use of VIOXX®? _____

   _____

   b. When do you claim this injury occurred?_____

   c. Who diagnosed the condition? _____

   d. Did you ever suffer this type of injury prior to the date set forth in answer to the prior question? Yes _____ No _____ ***If "yes,"*** when and who diagnosed the condition at that time? _____

   _____

   _____

   e. Do you claim that that your use of VIOXX® worsened a condition that you already had or had in the past? Yes ____ No _____ ***If "yes,"*** set forth the injury or condition; whether or not you had already recovered from that injury or condition before you took VIOXX®; and the date of recovery, if any. _____

   _____

D. Are you claiming mental and/or emotional damages as a consequence of VIOXX®? Yes ____ No ____

If "yes," for each provider (including but not limited to primary care physician, psychiatrist, psychologist, counselor) from whom have sought treatment for psychological, psychiatric or emotional problems during the last ten (10) years, state:

   a. Name and address of each person who treated you: _____

   _____

   b. To your understanding, condition for which treated: _____

   _____

   c. When treated: _____

   d. Medications prescribed or recommended by provider: _____

II. PERSONAL INFORMATION OF THE PERSON WHO USED VIOXX®

A. Name: _____

B. Maiden or other names used or by which you have been known: _____

C. Social Security Number: _____

D. Address: _____

E. Identify each address at which you have resided during the last ten (10) years, and list when you started and stopped living at each one:

Address	Dates of Residence

F. Driver's License Number and State Issuing License: _____

G. Date of Place and Birth: _____

H. Sex: Male ____ Female ____

I. Identify the highest level of education (high school, college, university or other educational institution) you have attended (even if not completed), the dates of attendance, courses of study pursued, and diplomas or degrees awarded:

Institution	Dates Attended	Course of Study	Diplomas or Degrees

J. Employment Information.

1. Current employer (if not currently employed, last employer):

Name	Address	Dates of Employment	Occupation/Job Duties

2. List the following for each employer you have had in the last ten (10) years:

Name	Address	Dates of Employment	Occupation/Job Duties

3. Are you making a wage loss claim for either your present or previous employment? Yes ____ No ____

If "yes," state your annual income at the time of the injury alleged in Section I(C):_____

K. Military Service Information: Have you ever served in the military, including the military reserve or national guard? Yes ____ No ____

If "yes," were you ever rejected or discharged from military service for any reason relating to your physical, psychiatric or emotional condition? Yes ____ No ____

L. Insurance / Claim Information:

1. Have you ever filed a worker's compensation and/or social security disability (SSI or SSD) claim? Yes ____ No ____ ***If "yes,"*** to the best of your knowledge please state:

   a. Year claim was filed: _____

   b. Nature of disability: _____

   c. Approximate period of disability: _____

2. Have you ever been out of work for more than thirty (30) days for reasons related to your health (other than pregnancy)? Yes ____ No ____ ***If "yes,"*** set forth when and the reason. _____
   _____
   _____

3. Have you ever filed a lawsuit or made a claim, other than in the present suit, relating to any bodily injury? Yes ____ No ____ ***If "yes,"*** state to the best of your knowledge the court in which such action was filed, case name and/or names of adverse parties, and a brief description for the claims asserted._____
   _____
   _____

M. As an adult, have you been convicted of, or plead guilty to, a felony and/or crime of fraud or dishonesty? Yes ____ No ____ ***If "yes,"*** set forth where, when and the felony and/or crime. _____

III.FAMILY INFORMATION

A. List for each marriage the name of your spouse; spouse's date of birth (for your current spouse only); spouse's occupation; date of marriage; date the marriage ended, if applicable; and how the marriage ended (e.g., divorce, annulment, death): _____

B. Has your spouse filed a loss of consortium claim in this action? Yes ____ No ____

C. To the best of your knowledge did any child, parent, sibling, or grandparent of yours suffer from any type of cardiovascular disease including but not limited to: heart attack, abnormal rhythm, arteriosclerosis (hardening or the arteries), murmur, coronary artery disease, congestive heart failure, enlarged heart, leaking valves or prolapse, heart block, congenital heart abnormality, Scarlet Fever, Rheumatic Fever, atrial fibrillation, stroke?
Yes ____ No ____ Don't Know _____ ***If "yes,"*** identify each such person below and provide the information requested.

Name: _____

Current Age (or Age at Death): _____

Type of Problem: _____

If Applicable, Cause of Death: _____

D. If applicable, for each of your children, list his/her name, age and address: _____

E. If you are claiming the wrongful death of a family member, list any and all heirs of the decedent. _____

IV. VIOXX® PRESCRIPTION INFORMATION

A. Who prescribed VIOXX® for you? _____

B. On which dates did you begin to take, and stop taking, VIOXX®? _____

C. Did you take VIOXX® continuously during that period?
Yes _____ No _____ Don't Recall _____

D. To your understanding, for what condition were you prescribed VIOXX®? _____

E. Did you renew your prescription for VIOXX®? Yes ____ No ____ Don't Recall ____

F. If you received any samples of VIOXX®, state who provided them, what dosage, how much and when they were provided: _____

G. Which form of VIOXX® did you take (check all that apply)?
_____ 12.5 mg Tablet (round, cream, MRK 74)
_____ 12.5 mg Oral Suspension
_____ 25 mg Tablet (round, yellow, MRK 110)
_____ 25 mg Oral Suspension
_____ 50 mg Tablet (round, orange, MRK 114)

H. How many times per day did you take VIOXX®?

_____

I. Did you request that any doctor or clinic provide you with VIOXX® or a prescription for VIOXX®? Yes ____ No ____ Don't Recall _____

J. Instructions or Warnings:

1. Did you receive any written or oral information about VIOXX® before you took it? Yes __ No ____ Don't Recall _____
2. Did you receive any written or oral information about VIOXX® while you took it? Yes ___ No _____ Don't Recall _____
3. ***If "yes,"***
   a. When did you receive that information?_____
   b. From whom did you receive it?_____
   c. What information did you receive? ____
      _____

K. What over-the-counter pain relief medications, if any, were you taking at the same time you were taking VIOXX®? _____
_____

V. MEDICAL BACKGROUND

A. Height: _____

B. Current Weight: _____
Weight at the time of the injury, illness, or disability described in Section I(C): _____

C. Smoking/Tobacco Use History: ***Check the answer and fill in the blanks applicable to your history of smoking and/or tobacco use.***

___ Never smoked cigarettes/cigars/pipe tobacco or used chewing tobacco/snuff.

___ Past smoker of cigarettes/cigars/pipe tobacco or used chewing tobacco/snuff.
   a. Date on which smoking/tobacco use ceased: _____
   b. Amount smoked or used: on average_____ per day for _____ years.

___ Current smoker of cigarettes/cigars/pipe tobacco or user of chewing tobacco/snuff.
   a. Amount smoked or used: on average _____ per day for _____ years.

___ Smoked different amounts at different times.

D. Drinking History. Do you now drink or have you in the past drank alcohol (beer, wine, whiskey, etc.)? Yes ____ No ____ ***If "yes," fill in the appropriate blank*** with the number of drinks that represents your average alcohol consumption during the period you were taking VIOXX® up to the time that you sustained the injuries alleged in the complaint:

_____ drinks per week,

_____ drinks per month,

_____ drinks per year, ***or***

Other (describe): _____

E. Illicit Drugs. Have you ever used (even one time) any illicit drugs of any kind within one (1) year before, or any time after, you first experienced your alleged VIOXX®-related injury?" Yes ____ No ____ Don't Recall _____

If "yes", identify each substance and state when you first and last used it. _____

_____

F. Please indicate to the best of your knowledge whether you have ever received any of the following treatments or diagnostic procedures:

1. Cardiovascular surgeries, including, but not limited to, the following, and specify for what condition the surgery was performed: open heart/bypass surgery, pacemaker implantation, vascular surgery, IVC filter placement, carotid (neck artery) surgery, lung resection, intestinal surgery:

Surgery	Condition	When	Treating Physician	Hospital

2. Treatments/interventions for heart attack, angina (chest pain), or lung ailments:

Treatment/Intervention	When	Treating Physician	Hospital

3. To your knowledge, have you had any of the following tests performed: chest X-ray, CT scan, MRI, angiogram, EKG, echocardiogram, TEE (trans-esophageal echo), bleeding scan, endoscopy, lung bronchoscopy, carotid duplex/ultrasound, MRI/MRA of the head/neck, angiogram of the head/neck, CT scan of the head, bubble/microbubble study, or Holter monitor?
Yes _____ No _____ Don't Recall _____ ***If "yes,"*** answer the following:

Diagnostic Test	When	Treating Physician	Hospital	Reason

VI. DOCUMENTS

Please indicate if any of the following documents and things are currently in your possession, custody, or control, or in the possession, custody, or control of your lawyers by checking ***"yes"*** or ***"no."*** Where you have indicated ***"yes,"*** please attach the documents and things to your responses to this profile form.

A. Records of physicians, hospitals, pharmacies, and other healthcare providers identified in response to this profile form. Yes ____ No ____

B. Decedent's death certificate (if applicable). Yes ____ No ____

C. Report of autopsy of decedent (if applicable). Yes ____ No ____

VII. LIST OF MEDICAL PROVIDERS AND OTHER SOURCES OF INFORMATION

List the name and address of each of the following:

A. Your current family and/or primary care physician:

Name	Address

B. To the best of your ability, identify each of your primary care physicians for the last ten (10) years.

Name	Address	Approximate Dates

C. Each hospital, clinic, or healthcare facility where you have received inpatient treatment or been admitted as a patient during the last ten (10) years.

Name	Address	Admission Dates	Reason for Admission

D. Each hospital, clinic, or healthcare facility where you have received outpatient treatment (including treatment in an emergency room) during the last ten (10) years.

Name	Address	Admission Dates	Reason for Admission

E. Each physician or healthcare provider from whom you have received treatment in the last ten (10) years.

Name	Address	Dates of Treatment

F. Each pharmacy that has dispensed medication to you in the last ten (10) years.

Name	Address

G. If you have submitted a claim for social security disability benefits in the last ten (10) years, state the name and address of the office that is most likely to have records concerning your claim.

Name	Address

H. If you have submitted a claim for worker's compensation, state the name and address of the entity that is most likely to have records concerning your claim.

Name	Address

CERTIFICATION

I declare under penalty of perjury subject to 28 U.S.C. § 1746 that all of the information provided in this Profile Form is true and correct to the best of my knowledge, that I have completed the List of Medical Providers and Other Sources of Information appended hereto, which is true and correct to the best of my knowledge, that I have supplied all the documents requested in part VI of this declaration, to the extent that such documents are in my possession, custody, or control, or in the possession, custody, or control of my lawyers, and that I have supplied the authorizations attached to this declaration.

Signature	Print Name	Date

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF LOUISIANA

In re: VIOXX® PRODUCTS LIABILITY LITIGATION

MDL No. 1657

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS PURSUANT TO 45 C.F.R. § 164.508 (HIPAA)

Name:_____

Date of Birth:_____

Social Security Number:_____

I hereby authorize _____ to release all existing medical records regarding the above-named person's medical care, treatment, physical condition, and/or medical expenses to the law firm of **HUGHES HUBBARD & REED LLP, 101 Hudson Street, Suite 3601, Jersey City, New Jersey 07302, and/or to the law firm of _____ and/or their designated agents ("Receiving Parties").** These records shall be used or disclosed solely in connection with the currently pending VIOXX® litigation involving the person named above. This authorization shall cease to be effective as of the date on which the above-named person's VIOXX® litigation concludes. The Receiving Parties shall return or destroy the protected health information (including all copies made) at the end of the above-named person's litigation or proceeding.

I understand that the health information being used/disclosed may include information relating to the diagnosis and treatment of Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS), sexually transmitted disease and drug and alcohol disorders.

This authorization also may include x-ray reports, CT scan reports, MRI scans, EEGs, EKGs, sonograms, arteriograms, discharge summaries, photographs, surgery consent forms, admission and discharge records, operation records, doctor and nurses notes (excluding psychotherapy notes maintained separately from the individual's medical record that document or analyze the contents of conversation during a private counseling session or a group, joint, or family counseling session by referring to something other than medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis and progress), prescriptions, medical bills, invoices, histories, diagnoses, narratives, and any correspondence/memoranda and billing information. It also includes, to the extent such records currently exist and are in your possession, insurance records, including Medicare/Medicaid and other public assistance claims, applications, statements, eligibility material, claims or claim disputes, resolutions and payments,

medical records provided as evidence of services provided, and any other documents or things pertaining to services furnished under Title XVII of the Social Security Act or other forms of public assistance (federal, state, local, etc.). This listing is not meant to be exclusive.

This will further authorize you to provide updated medical records, x-rays, reports or copies thereof to the above attorney until the conclusion of the litigation. I understand that I have the right to revoke in writing my consent to this disclosure at any time, except to the extent that the above-named facility or provider already has taken action in reliance upon this authorization, or if this authorization was obtained as a condition of obtaining insurance coverage. I further understand that the above-named facility or provider cannot condition the provision of treatment, payment, enrollment in a health plan or eligibility for benefits on my provision of this authorization. I further understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient to its clients, agents, employees, consultants, experts, the court, and others deemed necessary by the recipient to assist in this litigation and may no longer be protected by HIPAA. I further reserve the right to request the return or redaction of sensitive or embarrassing information, not germane to the litigation, that is disclosed to the Receiving Parties.

Any photostatic copy of this document shall have the same authority as the original, and may be substituted in its place. Copies of these materials are to be provided at the expense of Hughes Hubbard & Reed LLP or _____.

Dated this __ day of _____, 200__

_____

[*PLAINTIFF OR REPRESENTATIVE*]

If a representative, please describe your relationship to the plaintiff and your authority to act on his/her behalf:_____

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF LOUISIANA

In re: VIOXX® PRODUCTS LIABILITY LITIGATION	MDL No. 1657 **AUTHORIZATION FOR RELEASE OF PSYCHOLOGICAL/PSYCHIATRIC RECORDS PURSUANT TO 45 C.F.R. § 164.508 (HIPAA)**

Name:_____

Date of Birth:_____

Social Security Number:_____

I hereby authorize _____ to release all existing records regarding the above-named person's psychological or psychiatric care, treatment, condition, and/or expenses to the law firm of **HUGHES HUBBARD & REED LLP, 101 Hudson Street, Suite 3601, Jersey City, New Jersey 07302, and/or to the law firm of _____ and/or their designated agents ("Receiving Parties").** These records shall be used or disclosed solely in connection with the currently pending VIOXX® litigation involving the person named above. This authorization shall cease to be effective as of the date on which the above-named person's VIOXX® litigation concludes. The Receiving Parties shall return or destroy the protected health information (including all copies made) at the end of the above-named person's litigation or proceeding.

I understand that this authorization includes information regarding the diagnosis and treatment of psychiatric and psychological disorders, and that the health information being used/disclosed may include information relating to the diagnosis and treatment of Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS), sexually transmitted disease and drug and alcohol disorders.

This authorization also may include x-ray reports, CT scan reports, MRI scans, EEGs, EKGs, sonograms, arteriograms, discharge summaries, photographs, surgery consent forms, admission and discharge records, operation records, doctor and nurses notes (excluding psychotherapy notes maintained separately from the individual's medical record that document or analyze the contents of conversation during a private counseling session or a group, joint, or family counseling session by referring to something other than medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis and progress), prescriptions, medical bills, invoices, histories, diagnoses, psychiatric treatment and counseling records, psychological treatment and counseling records, narratives, and any correspondence/memoranda and billing

information. It also includes, to the extent such records currently exist and are in your possession, insurance records, including Medicare/Medicaid and other public assistance claims, applications, statements, eligibility material, claims or claim disputes, resolutions and payments, medical records provided as evidence of services provided, and any other documents or things pertaining to services furnished under Title XVII of the Social Security Act or other forms of public assistance (federal, state, local, etc.). This listing is not meant to be exclusive.

This will further authorize you to provide updated medical records, x-rays, reports or copies thereof to the above attorney until the conclusion of the litigation. I understand that I have the right to revoke in writing my consent to this disclosure at any time, except to the extent that the above-named facility or provider already has taken action in reliance upon this authorization, or if this authorization was obtained as a condition of obtaining insurance coverage. I further understand that the above-named facility or provider cannot condition the provision of treatment, payment, enrollment in a health plan or eligibility for benefits on my provision of this authorization. I further understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient to its clients, agents, employees, consultants, experts, the court, and others deemed necessary by the recipient to assist in this litigation and may no longer be protected by HIPAA. I further reserve the right to request the return or redaction of sensitive or embarrassing information, not germane to the litigation, that is disclosed to the Receiving Parties.

Any photostatic copy of this document shall have the same authority as the original, and may be substituted in its place. Copies of these materials are to be provided at the expense of Hughes Hubbard & Reed LLP or _____.

Dated this __ day of _____, 200__

_____

[*PLAINTIFF OR REPRESENTATIVE*]

If a representative, please describe your relationship to the plaintiff and your authority to act on his/her behalf: _____

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF LOUISIANA

In re: VIOXX® PRODUCT LIABILITY LITIGATION

MDL No. 1657

AUTHORIZATION FOR RELEASE OF PSYCHOTHERAPY NOTES PURSUANT TO 45 C.F.R. § 164.508 (HIPAA)

Name:_____

Date of Birth:_____

Social Security Number:_____

I hereby authorize _____ to release all existing psychotherapy notes regarding the above-named person's medical care, treatment, physical/mental condition, and/or medical expenses to law firm of **HUGHES HUBBARD & REED LLP, 101 Hudson Street, Suite 3601, Jersey City, New Jersey 07302, and/or to the law firm of _____ and/or their designated agents ("Receiving Parties").** These records shall be used or disclosed solely in connection with the currently pending VIOXX® litigation involving the person named above. This authorization shall cease to be effective as of the date on which the above-named person's VIOXX® litigation concludes. The Receiving Parties shall return or destroy the protected health information (including all copies made) at the end of the above-named person's litigation or proceeding.

I understand that this authorization includes all psychotherapy notes maintained separately from the above-named person's medical record that document or analyze the contents of conversation during a private counseling session or a group, joint, or family counseling session by referring to something other than medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis and progress.

I understand that the health information being disclosed by these psychotherapy notes may include information relating to the diagnosis and treatment of Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS), sexually transmitted disease and drug and alcohol disorders.

This will further authorize you to provide updated medical records, x-rays, reports or copies thereof to the above attorney until the conclusion of the litigation. I understand that I have the right to revoke in writing my consent to this disclosure at any time, except to the extent that the above-named facility or provider already has taken action in reliance upon this

authorization, or if this authorization was obtained as a condition of obtaining insurance coverage. I further understand that the above-named facility or provider cannot condition the provision of treatment, payment, enrollment in a health plan or eligibility for benefits on my provision of this authorization. I further understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient to its clients, agents, employees, consultants, experts, the court, and others deemed necessary by the recipient to assist in this litigation and may no longer be protected by HIPAA. I further reserve the right to request the return or redaction of sensitive or embarrassing information, not germane to the litigation, that is disclosed to the Receiving Parties.

Any photostatic copy of this document shall have the same authority as the original, and may be substituted in its place. Copies of these materials are to be provided at the expense of Hughes Hubbard & Reed LLP or _____.

Dated this __ day of _____, 200__

_____
[*PLAINTIFF OR REPRESENTATIVE*]

If a representative, please describe your relationship to the plaintiff and your authority to act on his/her behalf:_____

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF LOUISIANA

In re: VIOXX® PRODUCTS LIABILITY LITIGATION

MDL No. 1657

AUTHORIZATION FOR RELEASE OF RECORDS (To be signed by plaintiffs making a claim for lost wages, earnings or earning capacity.)

Name:_____

Date of Birth:_____

Social Security Number:_____

I hereby authorize _____ to release all existing records and information in its possession regarding the above-named person's employment, income and education to the law firm of **HUGHES HUBBARD & REED LLP, 101 Hudson Street, Suite 3601, Jersey City, New Jersey 07302, and/or to the law firm of _____ and/or their designated agents ("Receiving Parties").** These records shall be used or disclosed solely in connection with the currently pending VIOXX® litigation involving the person named above. This authorization shall cease to be effective as of the date on which the above-named person's VIOXX® litigation concludes.

I understand that this authorization includes the above-named person's complete employment personnel file (including attendance reports, performance reports, W-4 forms, W-2 forms, medical reports, workers' compensation claims), and also includes all other records relating to employment, past and present, all records related to claims for disability, and all educational records (including those relating to courses taken, degrees obtained, and attendance records). This listing is not meant to be exclusive.

Any photostatic copy of this document shall have the same authority as the original, and may be substituted in its place. Copies of these materials are to be provided at the expense of Hughes Hubbard & Reed LLP or _____.

Dated this __ day of _____, 200__

_____
[*PLAINTIFF OR REPRESENTATIVE*]

If a representative, please describe your relationship to the plaintiff and your authority to act on his/her behalf:_____

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF LOUISIANA

In re: VIOXX® PRODUCTS LIABILITY LITIGATION

Case No. 1657

AUTHORIZATION FOR RELEASE OF RECORDS (To be signed by plaintiffs *not* making a claim for lost wages or earnings or earning capacity.)

Name:_____

Date of Birth:_____

Social Security Number:_____

I hereby authorize _____ to release all existing records and information in its possession regarding the above-named person's employment and education (with the exception of W-4 and W-2 forms) to the law firm of **HUGHES HUBBARD & REED LLP, 101 Hudson Street, Suite 3601, Jersey City, New Jersey 07302, and/or to the law firm of _____ and/or their designated agents ("Receiving Parties").** These records shall be used or disclosed solely in connection with the currently pending VIOXX® litigation involving the person named above. This authorization shall cease to be effective as of the date on which the above-named person's VIOXX® litigation concludes.

I understand that this authorization includes the above-named person's complete employment personnel file with the exception of W-4 and W-2 forms (including attendance reports, performance reports, medical reports, workers' compensation claims), and also includes all other records relating to employment, past and present, all records related to claims for disability, and all educational records (including those relating to courses taken, degrees obtained, and attendance records). This listing is not meant to be exclusive.

Any photostatic copy of this document shall have the same authority as the original, and may be substituted in its place. Copies of these materials are to be provided at the expense of Hughes Hubbard & Reed LLP or _____.

Dated this __ day of _____, 200__

_____
[*PLAINTIFF OR REPRESENTATIVE*]

If a representative, please describe your relationship to the plaintiff and your authority to act on his/her behalf:_____

IN RE: PROPULSID® LITIGATION

THIS RELATES TO:

Civil Action No:

[plaintiff's name]

v.

[defendants' names]

MDL Docket No. 1355

PATIENT PROFILE FORM

Please provide to the best of your knowledge the following information for each individual on whose behalf a claim is being made. If you are completing this questionnaire in a representative capacity, please respond to the remaining questions with respect to the person who used Propulsid. Those questions using the term "You" refer to the person who used Propulsid. In filling out this form, please use the following definitions: (1) "health care - provider" means any hospital, clinic, center, physician's office, infirmary, medical or diagnostic laboratory, or other facility that provides medical, dietary, psychiatric or psychological care or advice, and any pharmacy, weight loss center, counselor, dentist, x-ray department, laboratory, physical therapist or physical therapy department, rehabilitation specialist, physician, psychiatrist, osteopath, homeopath, chiropractor, psychologist, therapist, nurse, herbalist, nutritionist, dietician, or other persons or entities involved in the evaluation, diagnosis, care and/or treatment of you; (2) "document" means any writing or record of every type that is in your possession, including but not limited to written documents, cassettes, videotapes, photographs, charts, computer discs or tapes, and x-rays, drawings, graphs, phono-records, non-identical copies and other data compilations from which information can be obtained and translated, if necessary, by the respondent through electronic devices into reasonably usable form. You may attach as many sheets of paper as necessary to fully answer these questions.

If you are completing this questionnaire in a representative capacity (on behalf of the estate of a deceased person or a minor), please state:

1. Your name _____

2. Address _____

3. In what capacity you are representing the individual _____

4. If you were appointed by a court, state the court & date of appointment_____

5. Your relationship to deceased or represented person_____

6. If you represent a decedent's estate, state the date of death of decedent_____

I. Personal Data

a. Name: _____

b. Any other names used and dates of use:_____

c. Address: _____

d. Date when began living at current address: _____

e. All prior addresses during last ten years and corresponding dates:

_____

_____

_____

f. Social Security Number: _____

g. Date and place of birth: _____

h. Date of Death, if applicable: _____

i. Marital Status: _____

j. Name(s) of current and former spouse(s) and date(s) of marriage(s), if applicable:

_____

k. Name(s) and date(s) of birth of children, if applicable:

_____

_____

_____

_____

_____

_____

l. Current employer

(i) Name: _____

(ii) Address: _____

(iii) Duties: _____

(iv) Job title: _____

(v) Dates Employed: _____

(vi) Full-time or Part-time: _____

(vii) Are you making a wage loss claim? _____ Yes _____ No
If "yes," state your annual income:

(viii) Did you leave the job for a medical reason? _____ Yes _____ No
If "yes," describe why you left that job:

(ix) Name of Supervisor: _____

m. All employers (other than current employer) that you have had in the last ten years:

(i) Name: _____

(ii) Address: _____

(iii) Duties: _____

(iv) Job title: _____

(v) Dates Employed: _____

(vi) Full-time or Part-time: _____

(vii) Are you making a wage loss claim? _____ Yes _____ No
If "yes," state your annual income:

(viii) Did you leave the job for a medical reason? _____ Yes _____ No
If "yes," describe why you left that job:

(ix) Name of Supervisor: _____

n. Schools you have attended (high school and beyond only):

(i) <u>High School</u>

(a) Name:

(b) Address:

(c) Grade completed:

(d) Year graduated:

(ii) Did you attend school beyond high school? _____ Yes _____ No

If "yes," then as to each school separately state:

(a) Name:
(b) Address:
(c) Dates of attendance:
(d) Degree awarded:
(e) Major or primary field

o. Has any insurance or other company provided medical coverage to you or paid medical bills on your behalf at any time beginning ten years prior to prescription of Propulsid® to the present? _____ Yes _____ No

If "yes," then as to each Company, separately state:

(i) Name of company:
(ii) Address of company:
(iii) When company made payments:
(iv) Medical conditions for which payments were made:

p. Have you ever applied for worker's compensation social security or state or federal disability benefits?

If "Yes," then as to each application, separately state:

(i) Date (or year) of application:
(ii) Type of benefits:
(iii) Amount awarded:
(iv) Basis of your claim:
(v) If denied, reason for denial:
(vi) To what agency or company did you submit your application (e.g. Maryland Division of Social Security):

q. Have you ever filed a lawsuit or made a claim, other than in the present suit, relating to any bodily injury?_____

If yes, state the court in which such action was filed and the civil action or docket number assigned to each such claim, action, or suit.

_____

_____

II. Health Care Providers

a. For each healthcare provider whom you have seen during the last fifteen (15) years, state:

(i) Name: ______________________________

(ii) Specialty, if any: ______________________________

(iii) Address: ______________________________

(iv) Phone: ______________________________

(v) Reason(s) for Visit(s): ______________________________

____

(vi) Medications prescribed or recommended by provider: ______________________________

____

(i) Name: ______________________________

(ii) Specialty, if any: ______________________________

(iii) Address: ______________________________

(iv) Phone: ______________________________

(v) Reason(s) for Visit(s): ______________________________

____

(vi) Medications prescribed or recommended by provider: ______________________________

____

(i) Name: ______________________________

(ii) Specialty, if any: ______________________________

(iii) Address: ______________________________

(iv) Phone: ______________________________

(v) Reason(s) for Visit(s): ______________________________

____

(vi) Medications prescribed or recommended by provider: ______________________________

____

(i) Name: ______________________________

(ii) Specialty, if any: ______________________________

(iii) Address: ______________________________

(iv) Phone: ______________________________

(v) Reason(s) for Visit(s): ______________________________

____

(vi) Medications prescribed or recommended by provider: ______________________________

____

(i) Name: _____
(ii) Specialty, if any:_____
(iii) Address: _____
(iv) Phone: _____
(v) Reason(s) for Visit(s): _____
_____
(vi) Medications prescribed or recommended by provider: _____
_____

*Please attach additional pages if necessary

b. For each hospitalization that you have undergone in the last fifteen (15) years, state:
(i) Name: _____
(ii) Address:_____
(iii) Phone:_____
(iv) Reason(s) for Hospitalization(s):_____
_____
_____

(i) Name: _____
(ii) Address:_____
(iii) Phone:_____
(iv) Reason(s) for Hospitalization(s):_____
_____
_____

(i) Name: _____
(ii) Address:_____
(iii) Phone:_____
(iv) Reason(s) for Hospitalization(s):_____
_____
_____

*Please attach additional pages if necessary.

c. For each surgery you have undergone in the last fifteen (15) years, state:

(i) Name of operation:_____
(ii) Name of surgeon_____
(iii) Address of surgeon_____
(iv) Reason for surgery_____

d. Have you ever consulted a physician or a clinic facility regarding any gastrointestinal condition or disease including but not limited to heartburn, ulcers, gastroenteritis,

bleeding, pain? If yes, state:

(i) Name of doctor or facility_____
(ii) Address_____
(iii) Date_____
(iv) Diagnosis_____
(v) Treatment_____
(vi) Medications_____
(vii) Did condition resolve?_____
(viii) Current status of condition_____

e. Have you ever had any of the following tests to evaluate for cardiac/heart disease or abnormality:

(i) Electrocardiogram [EKG/ECG]_____
(ii) Cardiac Catheterization_____
(iii) Exercise Stress Test_____
(iv) Holter Monitor_____
(v) Thallium Scan_____
(vi) Echocardiogram_____
(vii) Other diagnostic test of heart, lungs or cardiopulmonary blood vessels

---

If yes, please state separately for each:

(i) Type of test_____
(ii) Date administered_____
(iii) Reason for test_____
(iv) Facility name and address_____
(v) Ordering doctor_____
(vi) Results/diagnosis_____
(vii) Treatment_____

f. Have you to the best of your knowledge ever had any of the following tests to evaluate for gastrointestinal disease or abnormality:

(i) Upper GI Series_____
(ii) Barium Swallow_____
(iii) Esophagram_____
(iv) Small bowel x-ray_____
(v) Esophagoscopy_____
(vi) Endoscopy_____
(vii) Gastroscopy_____
(viii) Colonoscopy_____

(ix) Other diagnostic test or imaging of the gastrointestinal tract_____

If yes, please state separately for each:

(i) Type of test_____
(ii) Date administered_____
(iii) Reason for test_____
(iv) Facility name and address_____
(v) Ordering doctor_____
(vi) Results/diagnosis_____
(vii) Treatment_____

III. Medical Background

a. Height:_____

b. Weight_____

c. Smoking History

1. never smoked cigarettes_____

2. past smoker of cigarettes_____
date on which smoking ceased_____
Amount smoked: _____ packs per day for _____ years

3. current smoker of cigarettes_____
Amount smoked: _____ packs per day for _____ years

IV. Propulsid®

a. Have you ever taken Propulsid®? _____ Yes _____No

b. If "yes," then separately state or identify:
(i) dosage(s):
(ii) date(s) of use:
(iii) the healthcare provider(s), who prescribed Propulsid® to you:
(iv) describe separately for each medication you have identified in 3b(i):
(v) person(s) or source from which you obtained Propulsid®
(vi) reason you understood you were prescribed Propulsid®

c. Did you receive any written or oral information about Propulsid® before you took it?
_____ Yes _____ No

d. Did you receive any written or oral information about Propulsid® while you took it?
_____ Yes _____ No

If you responded "yes" to 3c and/or 3d, separately state or describe:

(i) when you received that information:
(ii) from whom you received it:
(iii) what information you received:

e. Did you receive any written information regarding Propulsid®?

_____ Yes _____ No

If yes, please attach all such documentation in your possession.

V. Injuries, Symptoms, Diagnoses, Ailments & Damages

a. Are you claiming that you have or may develop any physical condition as a result of taking Propulsid®?
_____ Yes _____ No

If "yes," then for each such condition, separately state:
(i) Nature of condition;
(ii) The date you first became aware of it;
(iii) How you first became aware of it;
(iv) Whether (and if so, how) it has changed over time;
(v) For each such condition, have you consulted with healthcare provider(s)?
_____ Yes _____ No

If "yes" to subpart (v) then, as to each healthcare provider, state:
(A) the healthcare provider's name;
(B) the healthcare provider's address;
(C) the date of first consultation with that healthcare provider;
(D) date of last consultation;
(E) do you plan to continue to consult with that healthcare provider?
_____Yes_____No

b. Has any healthcare provider told you, orally or in writing, that any of these conditions are due to your use of any of Propulsid®?
_____Yes _____ No

If "yes," then state and describe:
(i) what you were told;
(ii) who told you and when;

c. Are you claiming that you have paid or will have to pay any expenses as a result of having taken Propulsid®?
_____Yes _____No

If "yes," then for each item separately identify:
(i) for what:
(ii) amount of fees or expenses:
(iii) person or company paid or to be paid.

d. Other than those previously identified, are you claiming that you have suffered any other injuries or damages (including any alleged mental, emotional, psychological or psychiatric injuries or damages) as a result of taking Propulsid®?
_____ Yes _____ No

If "yes," then for each such condition, separately state:
(i) Nature of condition;
(ii) The date you first became aware of it;
(iii) How you first became aware of it;
(iv) Whether (and if so, how) it has changed over time;
(v) For each such condition, have you consulted with healthcare provider(s)?
_____ Yes _____ No

If "yes" to subpart (d) then, as to each healthcare provider, state:
(A) the healthcare provider's name;
(B) the healthcare provider's address;
(C) the date of first consultation with that healthcare provider;
(D) date of last consultation;
(E) do you plan to continue to consult with that healthcare provider?
_____Yes_____No

VI. Other Medications, Supplements, Or Drugs

Indicate to the best of your knowledge whether you ever took the medication during a time when you were taking Propulsid. If yes, please indicate dates taken and prescribing doctor under comments section.

	YES	NO	IF YES, DATES TAKEN, PRESCRIBING DOCTOR	NAME AND ADDRESS OF PHARMACY WHERE OBTAINED
ANTI-INFECTIVE DRUGS:				
Biaxin [Clarithromycin]	____	____	_____	_____
Cipro [Ciprofloxaxin]	____	____	_____	_____
Crixivan [Indinavir]	____	____	_____	_____
Diflucan [Fluconazole]	____	____	_____	_____
Erythrocin & others [Erythromycin]	____	____	_____	_____

Flagyl [Metronidazole]	____	____	_____	_____
Keflex [Cephalexin]	____	____	_____	_____
Nizoral [Ketoconazole]	____	____	_____	_____
Norvir [Ritonavir]	____	____	_____	_____
Sporanox [Itraconazole]	____	____	_____	_____
TAO [Troleandomycin]	____	____	_____	_____
Zagam [Sparfloxacin]	____	____	_____	_____

ANTIDEPRESSANTS:

Adapin, Sinequan [Doxepin]	____	____	_____	_____
Elavil [Amitriptylene]	____	____	_____	_____
Lithobid, Eskalith [Lithium]	____	____	_____	_____
Ludiomil [Maprotilene]	____	____	_____	_____
Norpramin [Desipramine]	____	____	_____	_____
Pamelor [Nortriptylene]	____	____	_____	_____
Prozac [Fluoxetine]	____	____	_____	_____
Remeron [Mirtazapine]	____	____	_____	_____
Serzone [Nefazadone]	____	____	_____	_____
Tofranil [Imipramine]	____	____	_____	_____

CARDIOVASCULAR DRUGS:

Adalat [Nifedipine]	____	____	_____	_____
Betapace [Sotalol]	____	____	_____	_____
Cardiazem [Diltiazem]	____	____	_____	_____
Cordarone [Amiodarone]	____	____	_____	_____
Dyazide [HCTZ/Triamterene]	____	____	_____	_____
Hydrodiuril [Hydrochlorothiazide]	____	____	_____	_____
Inderal [Propranalol]	____	____	_____	_____
Lanoxin [Digoxin]	____	____	_____	_____
Lasix [Furosemide]	____	____	_____	_____
Norpace [Disopyramide]	____	____	_____	_____
Pronestyl [Procainamide]	____	____	_____	_____
Quinidex [Quinidine]	____	____	_____	_____
Tenormin [Atenolol]	____	____	_____	_____
Vascor [Bepridil]	____	____	_____	_____

CENTRAL NERVOUS SYSTEM DEPRESSANTS:

Compazine [Prochlorperazine]	____	____	_____	_____
Haldol [Haloperidol]	____	____	_____	_____
Mellaril [Thioridazine]	____	____	_____	_____
Serdolect [Sertindole]	____	____	_____	_____
Thorazine [Chlorpromazine]	____	____	_____	_____
Triavil, Trilfon [Perphenazine]	____	____	_____	_____

OTHER:

Hismanal [Astemizole]	____	____	_____	_____
Luvox [Fluvoxamine]	____	____	_____	_____
Mevacor [Lovastatin]	____	____	_____	_____
Terodilene	____	____	_____	_____

VII. Family History

1. To the best of your knowledge did any child, parent, sibling, aunt, uncle, or grandparent of yours suffer from any type of heart disease including but not limited to: abnormal rhythm, arteriosclerosis (hardening of the arteries), murmur, coronary artery disease, congestive heart failure, enlarged heart, leaking valves or prolapse, heart block, congenital heart abnormality, Scarlet Fever, Rheumatic Fever, atrial fibrillation?
   yes_____ no_____

2. If yes, then state separately for each:
   relative's name_____
   relationship to you_____
   type of heart problem_____
   date and cause of death if applicable_____

3. For infants and young children: was Propulsid® used during a period of time while the child was being breastfed? Yes ____ No ____ . If yes, please answer questions II and VI for the nursing mother limited to the period of time that the child was both breast fed and taking Propulsid®.

VIII. Authorizations

Complete and sign the attached Authorization for Release of Hospital, Medical and Pharmacy Records. If you are making a wage loss claim, then sign the attached Authorization for release of employment records.

I acknowledge that I have an obligation to supplement the above responses if I learn that they are in some material respects incomplete or incorrect.

I verify under oath that the above responses are true and correct to the best of my knowledge.

Date:_____ _____
Signature

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF WEST VIRGINIA

CHARLESTON DIVISION

MDL No. 2327
In Re Ethicon Inc., Pelvic Repair System Products Liability Litigation

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In completing this Plaintiff Profile Form, you are under oath and must provide information that is true and correct to the best of your knowledge. The Plaintiff Profile Form shall be completed in accordance with the requirements and guidelines set forth in the applicable Case Management Order.

I. CASE INFORMATION

Caption: _____ **Date:** _____

Docket No.: _____

Plaintiff's attorney and Contact information:

_____

_____

_____

_____

II. PLAINTIFF INFORMATION

Name: _____

Spouse: _____ **Loss of Consortium?** ☐Yes ☐ No

Address: _____

Date of birth: _____

Social Security No.: _____

III. DEVICE INFORMATION[1]

Date of implant: _____

Reason for Implantation: _____

Brand Name: _____ **Mfg.** _____

[1] Note: In lieu of device information, operating records may be submitted as long as all requested information is legible on the face of the record.

Lot Number: _____

Implanting Surgeon: _____

Medical Facility: _____

Date of implant: _____

Reason for Implantation: _____

Brand Name: _____ **Mfg.** _____

Implanting Surgeon: _____

Medical Facility: _____

• ***Attach medical evidence of product identification.***

IV. REMOVAL/REVISION SURGERY INFORMATION

Date of surgery(s): _____

Type of surgery(s): _____

Explanting surgeon: _____

Medical Facility: _____

Reason for Explant: _____

Date of surgery(s): _____

Type of surgery(s): _____

Explanting surgeon: _____

Medical Facility: _____

Reason for Explant: _____

V. OUTCOME ATTRIBUTED TO DEVICE

☐ **Pain**	☐ **Fistulae**
☐ **Erosion**	☐ **Recurrence**
☐ **Extrusion**	☐ **Bleeding**
☐ **Infection**	☐ **Dyspareunia**
☐ **Urinary Problems**	☐ **Neuromuscular problems**
☐ **Bowel Problems**	☐ **Vaginal Scarring**

☐ Organ Perforation	☐ Other

VI. PAST HISTORY

Number of Pregnancies: _____ Number of Live Births: _____

Date of Hysterectomy(ies) and Name of Hospital Where Performed: _____

Prior to the First Implant, Have You Ever Had:

_____ **Lupus**
_____ **Diabetes**
_____ **Auto Immune Disorder**
_____ **Endometriosis**
_____ **Pelvic Pain Syndrome or Disorder**
_____ **Fibroids**
_____ **Adhesive Disease**

Are you claiming damages for lost wages: [ ] Yes [ ] No

If so, for what time period: _____

Have you ever filed for bankruptcy: [ ] Yes [ ] No

If so, when? _____

Do you have a computer: [ ] Yes [ ] No

If so, are you a member of Facebook, LinkedIn or other social media websites: [ ] Yes [ ] No

Which ones: _____

VII. LIST OF ALL TREATING PHYSICIANS FOR THE PERIOD OF 10 YEARS PRIOR TO THE FIRST MESH IMPLANT, INCLUDING ALL PRIMARY CARE PHYSICIANS, OB-GYNS, UROLOGISTS, ENDOCRINOLOGISTS, RHEUMATOLOGISTS, PSYCHIATRISTS, PSYCHOLOGISTS, OR ANY OTHER SPECIALISTS

Primary Care Physicians:

Name: _____

Address: _____

Approximate Period of Treatment: _____

Name: _____

Address: _____

Approximate Period of Treatment: _____

OB-GYNs:

Name: _____

Address: _____

Approximate Period of Treatment: _____

Name: _____

Address: _____

Approximate Period of Treatment: _____

Urologists:

Name: _____

Address: _____

Approximate Period of Treatment: _____

Name: _____

Address: _____

Approximate Period of Treatment: _____

Psychiatrists/Psychologists (Answer only if making a claim for emotional/psychological Injury beyond usual pain and suffering):

Name: _____

Address: _____

Approximate Period of Treatment: _____

Name: _____

Address: _____

Approximate Period of Treatment: _____

Attach additional pages as needed to identify other health care providers you have seen.

AUTHORIZATIONS

Provide ONE (1) SIGNED ORIGINAL copy of each of the records authorization forms attached as Ex. A. These authorization forms will authorize the records vendor selected by the parties to obtain those records identified in the authorizations from the providers identified within this Plaintiff Profile Form.

VERIFICATION

I, _____, declare under penalty of perjury subject to all applicable laws, that I have carefully reviewed the final copy of this Plaintiff Profile Form dated _____ and verified that all of the information provided is true and correct to the best of my knowledge, information and belief.

_____
Signature of Plaintiff

SUPERIOR COURT OF NEW JERSEY
LAW DIVISION: ATLANTIC COUNTY

IN RE: FOSAMAX LITIGATION	)	
CASE NO. 282	)	
CIVIL ACTION	)	Plaintiff: _____
	)	Docket No. _____

PLAINTIFF PROFILE FORM

Please provide the following information regarding yourself or each individual on whose behalf a personal injury claim is being made. Each question must be answered in full. If you do not know or cannot recall the information needed to answer a question, please indicate that in response to the question. To the extent you cannot completely answer any question, please provide whatever information is available to you and, as to any information sought by the question which you do not know, please identify what part of the question you cannot answer. Do not leave any questions unanswered or blank.

Please attach as many sheets of paper as necessary to fully answer these questions.

In filling out this form, please use the following definitions:

(1) "**health care provider**" or "**health care practitioner**" means any hospital, clinic, center, physician's office, dentist's office, infirmary, medical or diagnostic laboratory, or other facility that provides medical, dental, oral, psychiatric, mental, emotional or psychological care or advice, and any doctor, physician, surgeon, oncologist, radiologist, dentist, oral and maxillofacial surgeon pathologist, oral pathologist, natural health provider, homeopath, osteopath, chiropractor, paramedic, nurse (registered or otherwise), physiotherapist, psychologist, psychiatrist, therapist, or any other person practicing any healing art, or performing any physical, dental, oral, radiological, or mental evaluation or examination or other persons or entities involved in the evaluation, diagnosis, care and/or treatment of you;

(2) "**document**" means any writing or record of every type that is in your possession or the possession of your counsel, including but not limited to written documents, e-mails, cassettes, videotapes, photographs, charts, computer discs or tapes, x-rays, drawings, graphs, non-identical copies and other data compilations from which information can be obtained and translated, if necessary, by the respondent through electronic devices into any reasonably usable form.

(3) "**Fosamax**" means FOSAMAX® and FOSAMAX PLUS D®.

(4) "**Osteonecrosis of the jaw**" includes "avascular necrosis of the jaw," "aseptic necrosis of the jaw," and "ischemic necrosis of the jaw."

Other than in Section I(C), those questions using the term "You" should refer to the person who used Fosamax. You should attach as many sheets of paper as necessary to fully answer these questions.

If you have any documents (as defined above), that you are requested to produce in response to questions in this profile form or that relate to Fosamax or other bisphosphonate-containing products or medications you allegedly took, or to the incident, injuries, claims or damages that are the subject of your complaint or, if you have any unused Fosamax and its accompanying packaging, you are required to give all of these documents and materials to your attorney as soon as possible. If you are unclear about this obligation, please contact your attorney.

Whenever you are asked for the name and address of an individual or entity, you are to provide the full name and complete address for that individual or entity.

I. CASE INFORMATION

A. Name of person completing this form_____

B. Please state the following for the civil action which you have filed:

1. Case Caption: _____

2. Docket No.: _____

3. Please state the name, address, and telephone number of the principal attorney representing you:

_____
Name of attorney

_____
Firm name

_____
City, State and Zip Code

_____
Telephone number

C. If you are completing this questionnaire on behalf of someone else (*e.g.*, a deceased person, an incapacitated person), please complete the following:

_____
Your Name

_____
Address

_____
Social Security Number
In what capacity are you representing the individual? _____

_____

If you were appointed by a court, please provide a copy of the order of appointment or power of attorney/authorizing document and state the:

_____

Court Date of Appointment

What is your relationship to the deceased or represented person? ____

_____

If you represent a decedent's estate, state the date of the decedent's death:_____

D. Claim Information

1. Do you claim that you have suffered a physical injury as a result of Fosamax use? Yes _____ No _____

2. If the answer to the foregoing question is "yes," state the nature of the physical injury or injuries which you claim.

___ Osteonecrosis of the Jaw
___ Osteomyelitis of the Jaw
___ Increased Risk of Developing Osteonecrosis of the Jaw
___ Other (Please Specify): _____
___ Not claiming any physical injuries as a result of Fosamax use

a. When do you claim this injury occurred?_____
(month/day/year)

b. Date of diagnosis: _____
(month/day/year)

c. Name, address, telephone number and specialty of the person who diagnosed this injury: _____

_____

_____

d. Name, address, telephone number and specialty of the person who treated this injury: _____

_____

_____

3. Do you claim that you have suffered a psychological or emotional injury as a result of Fosamax use? Yes _____ No _____

4. If the answer to the foregoing question is "yes," state the nature of the psychological or emotional injury or injuries which you claim.

___ Depression
___ Anxiety
___ Other (Please Specify): _____
___ Not claiming any psychological or emotional injury as a result of Fosamax use

a. When do you claim this injury occurred?_____
(month/day/year)

b. Have you sought treatment for this psychological or emotional injury? Yes ____ No ____

c. Symptom(s):

_____

_____

d. Date(s) of onset: _____

e. Date of diagnosis: _____
(month/day/year)

f. Do you still have the injury? Yes ____ No _____

g. Name, address, telephone number and specialty of the person who first diagnosed this injury. _____

_____

_____

h. Name, address, telephone number and specialty of the person who treated this injury:_____

_____

_____

i. Medications prescribed or recommended:_____

_____

_____

j. Date(s) of treatment: _____

5. Have you had discussions with any physician(s), dentist(s), or other health care provider(s) about whether any injury described in section I(D) above is related to the use of Fosamax?

Yes _____No _____

If "yes," please identify:
Name(s) of health care provider(s):_____
Address(es):_____
Specialty:_____
Date(s) of Discussion(s):_____

a. Do you recall what you were told? Yes _____ No_____
b. **If "yes,"** what were you told? _____

_____

_____

_____

_____

[If you discussed with more than one health care provider, please separately identify what each individual said to you]

6. Do you claim that your treatment with Fosamax increased your risk of a future injury or harm that you have not yet experienced?
Yes _____ No _____

If "yes," identify and describe each and every such future injury or harm and for each, identify the basis for your contention._____
_____
_____

7. Have you had any discussions with any physician(s), dentist(s), or other health care provider(s) about whether your treatment with Fosamax or any other bisphosphonate puts you at increased risk of future injury or harm?
Yes _____ No _____ Don't Recall _____

If "yes," please identify:
Name of heath care provider(s):_____
Address:_____
Specialty:_____
Date(s) of Discussion(s):_____
State what the health care provider told you, including any description of the future injury or harm: _____
_____
_____
_____
_____

[If you discussed with more than one health care provider, please separately identify what each individual said to you]

8. If you do not claim to have suffered a physical, psychological, or emotional injury as a result of Fosamax use, state how you have been injured or damaged.
_____
_____
_____

II. PERSONAL INFORMATION OF THE PERSON WHO USED FOSAMAX

A. Name: _____

B. Maiden name(s) or any other name(s) by which you have been known (from prior marriages or otherwise, if any): _____

C. Gender: Male _____ Female _____

D. Social Security number: _____

E. Driver's license number: _____
State of issuance: _____

F. Date and place of birth (city, county, and state): _____
_____

G. Provide the full name, address, and age of each of your children: _____

_____

_____

H. Identify each address at which you have resided during the last ten (10) years, and list when you started and stopped living at each one:

Address	Dates of Residence

I. Complete the following information with respect to your employment for ten (10) years prior to your use of Fosamax or any other bisphosphonate to the present (If not employed during that period, state last employer).

Employer	Address	Occupation/ Job Duties	Dates of Employment	Salary/ Bonus/ Overtime

J. Within the last ten (10) years, have you been convicted of any felony or a crime involving dishonesty or false statement?
Yes _____ No _____

If "yes," please (1) identify the crime and/or felony, (2) when you were convicted or pled guilty, (3) where you were convicted or pled guilty, (4) whether you were incarcerated, and if so, for how long you were incarcerated.

_____

_____

_____

K. Are you making a claim for lost wages for either your present or previous employment? Yes ____ No ____

If "yes," identify your annual income at the time of the injury alleged in Section I(D): _____

L. Have you ever filed a lawsuit or brought any other type of legal claim aside from the present suit? Yes _____ No _____

If "yes," for each such lawsuit, state (1) the court in which such lawsuit was filed, (2) the case name, (3) the names of the adverse parties, (4) the civil action or docket number assigned to the lawsuit, (5) a description of your claims in the lawsuit, and (6) whether the lawsuit has been resolved and if so, how it was resolved._____

_____

_____

_____

M. Have you ever served in any branch of the U.S. Military? Yes ____ No ____

If "yes," please state:

1. What branch and the dates of service:_____
2. Were you discharged for any reason relating to your physical, psychiatric or emotional condition? Yes ____ No ____
   If **"yes,"** state what that condition was:_____
   _____
3. Have you ever been rejected from military service for any reason relating to your health or physical condition? Yes ____ No ____
   If **"yes,"** state what that condition was:_____
   _____
4. Have you ever served in the military overseas? Yes ____ No ____
   If **"yes,"** state location and dates:_____
   _____

N. Insurance / Claim Information

1. Have you ever filed a worker's compensation claim? Yes ____ No ____

   If "yes," to the best of your knowledge please state:

   a. Year claim was filed: _____
   b. Nature of disability: _____
   c. Approximate dates of disability: _____
   d. Resolution of claim: Denied ____ Granted ____ Other ____
      If "other," describe: _____
   e. Identify the full name and address of the entity most likely to have records concerning your claim: _____
   f. Full name and address of your employer against whom claim was filed:_____
      _____

2. Have you ever filed a social security disability (SSI or SSD) claim? Yes ____ No ____

   If "yes," to the best of your knowledge please state:

   a. Year claim was filed: _____
   b. Nature of disability: _____
   c. Approximate dates of disability: _____
   d. Resolution of claim: Denied ____ Granted ____ Other ____

If "other," describe: _____

e. Identify the full name and address of the entity most like to have records concerning your claim: _____

_____

3. Has any insurance or other company provided medical and/or dental coverage to you (either directly or through a group or employer) for the period beginning twelve (12) years before your first use of Fosamax or any other bisphosphonate through the present? Yes _____ No _____ Don't Recall _____

If "yes," then as to each such company, separately state:

a. Name of the company: _____

b. Address of the company: _____

_____

c. The account/policy number or designation: _____

d. Name of Primary Insured:_____

e. Dates of coverage: _____

f. It there are any insurance coverages for which you cannot recall all of the details, please describe those details that you can remember: ____

_____

_____

_____

III. EDUCATIONAL HISTORY

Identify each school, college, university and other educational institution you have attended, the dates of attendance, courses of study pursued and diplomas or degrees awarded. _____

_____

_____

_____

_____

_____

IV. FAMILY INFORMATION

A. Have you ever been married?
Yes _____ No _____

B. **If "yes,"** for each spouse/former spouse state:

1. Spouse's name: _____

2. Dates of marriage: _____

3. Spouse's date of birth: _____

4. Spouse's occupation: _____

5. Spouse's address and phone number: _____

_____

6. If applicable, why did the marriage end (*e.g.*, divorce, death)? _____

_____

7. If applicable, the date the marriage ended: _____

C. Have your grandparents, parents, siblings and children ever had or been diagnosed with or had osteonecrosis or osteomyelitis?
Yes _____ No _____

If "yes," state (1) the name and relationship of the person to you, (2) the disease(s) he or she has/had, and (3) the date of that individual's diagnosis. ___

_____

_____

V. DENTAL BACKGROUND FOR JAW RELATED INJURY CLAIMS

Please complete this section if you are claiming any jaw-related injury or you are claiming that you are at risk of any future jaw-related injury. If you are not claiming any such injury, please complete Section V (alternate) beginning on p. 13 below.

A. HABITS

1. On average, during the twelve (12) year period BEFORE you first used Fosamax, how often did you:

   a. Brush your teeth per week? _____

   b. Floss your teeth per week? _____

   c. See a dentist for routine check-ups, examinations or teeth cleaning? _____

   _____

2. On average, during the period AFTER you began using Fosamax, how often do you:

   a. Brush your teeth per week? _____

   b. Floss your teeth per week? _____

   c. See a dentist for routine check-ups, examinations or teeth cleaning? _____

   _____

B. DENTAL STATUS

1. Are you missing any teeth (including wisdom teeth or others)?

Yes _____ No _____ Don't Recall _____

If "yes," indicate the following:

a. How many are you missing? _____

b. Which teeth? _____

c. When and how did you lose each of those teeth? _____

_____

2. Were any of the missing teeth extracted? Yes _____ No _____ Don't Recall _____

If "yes," indicate the following:

a. How many? _____

b. Which teeth? _____

_____

c. When and why were these teeth extracted? _____

_____

d. Who performed each extraction? (please provide the name, address, telephone number and specialty of the person who performed each extraction(s)). _____

_____

_____

3. Have you ever had any dental implants, artificial fixtures (including dentures and bridges), or any dental prosthodontics or orthodontia (including braces)? Yes _____ No _____ Don't Recall _____

If "yes," indicate the following:

a. What type of dental implant(s), artificial fixture(s), or dental prosthodontics or orthodontia did you have? _____

_____

_____

b. Identify approximately when you received each dental implant, artificial fixture, or dental prosthodontics or orthodontia? _____

_____

_____

c. Please identify the teeth or the approximate locations in your mouth where you received dental implants, artificial fixtures, or dental prosthodontics or orthodontia? _____

_____

_____

d. Please provide the name, address, telephone number and specialty of the persons who installed or fitted your dental implants, artificial fixtures, or dental prosthodontics or orthodontia. _____

_____

_____

_____

e. Please describe any problems or complications you experienced relating to the dental implants, artificial fixtures, or dental prosthodontics or orthodontia you received? _____
_____
_____

4. Have you ever had any periodontal procedures? Yes ____ No _____ Don't Recall _____

If "yes," indicate the following:

a. What type of periodontal procedure(s) have you had? _____
_____

b. When did you receive each procedure? _____

c. Please provide the name, address, telephone number and specialty of the person who performed each procedure. _____
_____
_____

d. Did you have any problems or complications related to the periodontal procedure (describe each complication)? _____
_____
_____

5. Have you ever had a fracture of the jaw? Yes ____ No _____ Don't Recall _____

If "yes," indicate the following:

a. Date(s) of each fracture?_____

b. Describe how you suffered each fracture?_____
_____

c. Describe the portion(s) of the jaw fractured and the extent of the fracture(s):_____
_____

d. Please provide the name, address, and telephone number of each person who treated you for each fracture. _____
_____

C. Have you ever had or been diagnosed with any of the following conditions:

	Yes	No	Unknown
Osteonecrosis of the jaw			
Osteomyelitis			
Infection in the mouth			
Tori in the mouth			
Bone spurs in the mouth			
Exposed bone in the mouth			
Tooth decay			

	Yes	No	Unknown
Poor healing of infections in the mouth			
Gum disease or infection			
Periodontal disease			
Bleeding gums			
Temporomandibular joint [TMJ] problems			
Abscesses			
Lesions in the mouth			
Cancer of the mouth			
Herpes [in or around the mouth]			
Lockjaw			
Exostosis (bony outgrowth)			
Pain (persistent or otherwise) in the mouth or jaw			
Swelling in the mouth or jaw			
Non-healing sore in the mouth or jaw			
Draining fistula			
Numbness of the lip, chin, mouth or jaw			
"Heaviness" of the jaw			
Burning or tingling in the jaw			
Limited range of motion in the jaw			
Edentulous (toothless) regions in the mouth			
Lingual Mandibular Sequestration			
Osteoradionecrosis			
Other disease of the jaw or oral cavity Please specify:			

D. If you responded "**yes**" to any of the above, please provide the following information for each condition:

Condition	**Name and Address of Person(s) Who Diagnosed or Treated the Condition**	**Approximate Onset Date of Condition**

E. State whether you ever had any of the following dental or oral procedures/tests at any time.

	Yes	No	Unknown

	Yes	No	Unknown
Gingivectomy or gum resection			
Periodontal surgery			
Oral surgery			
Root canal or other endodontic procedure			
Root planing, scaling, or other treatment for gum disease			
Any invasive dental procedure			
Ridge smoothing			
Debridement of the oral cavity			
Bone trimming			
Apicoectomy			
Bone jaw biopsy			
Dental x-rays, panorexes, or other dental imaging			
Other diagnostic test or imaging of the mouth or jaw Please specify: _____			

F. For each procedure/test for which you answered "yes," please identify the following information:

Test/Procedure	Name and Address of Physician/Dentist Who Performed Test/Procedure	Approximate Dates of Treatment

V (ALT). DENTAL BACKGROUND FOR NON-JAW RELATED INJURY CLAIMS

Complete this section (Section V (alt.)) only if you did not complete Section V above.

A. DENTAL STATUS

1. Are you missing any teeth (including wisdom teeth or others)?
   Yes _____ No _____ Don't Recall _____
   If "yes," indicate the following:
   a. How many are you missing? _____
   b. Which teeth? _____
   c. When and how did you lose each of those teeth? _____
   _____

2. Were any of the missing teeth extracted? Yes _____ No _____ Don't Recall _____

If "yes," indicate the following:

a. How many? _____

b. Which teeth? _____

_____

c. When and why were these teeth extracted? _____

_____

d. Who performed each extraction? (please provide the name, address, telephone number and specialty of the person who performed each extraction(s)). _____

_____

_____

3. Have you ever had any dental implants, artificial fixtures (including dentures and bridges), or any dental prosthodontics or orthodontia (including braces)? Yes _____ No _____ Don't Recall _____

If "yes," indicate the following:

a. What type of dental implant(s), artificial fixture(s), or dental prosthodontics or orthodontia did you have? _____

_____

_____

b. Identify approximately when you received each dental implant, artificial fixture, or dental prosthodontics or orthodontia? _____

_____

_____

c. Please identify the teeth or the approximate locations in your mouth where you received dental implants, artificial fixtures, or dental prosthodontics or orthodontia? _____

_____

_____

d. Please provide the name, address, telephone number and specialty of the persons who installed or fitted your dental implants, artificial fixtures, or dental prosthodontics or orthodontia. _____

_____

_____

_____

e. Please describe any problems or complications you experienced relating to the dental implants, artificial fixtures, or dental prosthodontics or orthodontia you received? _____

_____

4. Have you ever had any periodontal procedures? Yes ____ No _____ Don't Recall _____

If "yes," indicate the following:

a. What type of periodontal procedure(s) have you had? _____

b. When did you receive each procedure? _____

c. Please provide the name, address, telephone number and specialty of the person who performed each procedure. _____

d. Did you have any problems or complications related to the periodontal procedure (describe each complication)? _____

5. Have you ever had a fracture of the jaw? Yes ____ No _____ Don't Recall _____

If "yes," indicate the following:

a. Date(s) of each fracture?_____

b. Describe how you suffered each fracture?_____

c. Describe the portion(s) of the jaw fractured and the extent of the fracture(s):_____

d. Please provide the name, address, and telephone number of each person who treated you for each fracture. _____

B. State whether you ever had any of the following dental or oral procedures, treatments, or tests at any time.

	Yes	No	Unknown
Gingivectomy or gum resection			
Periodontal surgery			
Oral surgery			
Root canal or other endodontic procedure			
Root planing, scaling, or other treatment for gum disease			
Any invasive dental procedure			
Ridge smoothing			
Debridement of the oral cavity			
Bone trimming			
Apicoectomy			
Bone jaw biopsy			

	Yes	No	Unknown
Intravenous antibiotics to treat a dental infection			

C. For each procedure/test for which you answered "yes," please identify the following information:

Test/Procedure	Name and Address of Physician/Dentist Who Performed Test/Procedure	Approximate Dates of Treatment

VI. OTHER MEDICAL BACKGROUND AND INFORMATION

A. To the best of your knowledge, did you use or take any of the following medications or substances BEFORE the injury that you allege you suffered occurred? **If "yes,"** please provide the first and last date on which you took the medication or substance.

	Yes	No	Date First Taken	Date Last Taken
Corticosteroids or other steroids				
Radiation therapy				
a. Head and/or Neck				
b. Other Body Part				
Chemotherapy				
Hormonal therapy (including, but not limited to, estrogen therapy, oral contraceptive, estrogen/progestin therapy, anti-estrogens, aromatase inhibitors, and anti-androgens/androgen deprivation therapy)				
Blood pressure (hypertension) medication				
Cholesterol-lowering medication				
Medication for the treatment of Rheumatoid Arthritis				
Medication for the treatment of Diabetes				
Selective Estrogen Receptor Modulators (SERMs), such as tamoxifen, Evista (raloxifene), Fareston (toremifene)				

B. Were you taking any other prescription medicines in the five (5) years prior to developing the injury you are claiming in this action?
Yes _____ No _____

If "yes," please list the medications, the first and last dates of ingestion, and reasons for taking each. _____
_____
_____

C. Have you participated in any clinical trials or taken any experimental drugs?
Yes _____ No _____

If "yes," please indicate when you participated in such trials, where the trials took place, which drugs you took, and for what condition you took such drugs. _____
_____
_____
_____
_____

D. Smoking/Tobacco Use History:

Do you now or have you ever smoked or used tobacco products?
Yes_____ No _____
If "yes," indicate with an "X" the answer and fill in the blanks applicable to your history of smoking and/or tobacco use

1. Current smoker of cigarettes ____; cigars ____; pipe tobacco ____; or user of chewing tobacco/snuff ____.
   a. Amount smoked or used: on average _____ per day for _____ years.
2. Past smoker of cigarettes ____; cigars ____; pipe tobacco ____; or used chewing tobacco/snuff ____.
   a. Date on which smoking/tobacco use ceased: _____
   b. Amount smoked or used: on average _____ per day for _____ years.

E. Alcoholic Beverage Consumption History

Do you now drink or have you in the past drunk alcohol (beer, wine, whiskey, etc.)? Yes ____ No ____
If "yes," fill in the appropriate blank with the number of drinks that represents your average alcohol consumption during the period you were taking Fosamax up to the time that you sustained the injuries alleged in the complaint:

_____ drinks per week,
_____ drinks per month,
_____ drinks per year, ***or***
Other (describe): _____

F. Have you ever experienced or been diagnosed or treated for any of the following:

	Yes	No	Unknown
1. Necrosis, avascular necrosis, aseptic necrosis or osteonecrosis in any part of the body			
2. Osteoporosis			
3. Paget's disease			
4. Pancytopenia or abnormal blood count secondary to cancer and/or cancer treatment			
5. Sickle cell disease			
6. Gaucher's disease			
7. Vascular diseases, problems, or insufficiencies			
8. Autoimmune or connective tissue disorders			
a. Systemic lupus erythematosus			
b. Rheumatoid arthritis			
c. Vasculitis			
d. Crohn's disease			
e. Reynaud's syndrome			
f. Sjogren's syndrome			
g. IBD (Inflammatory Bowel Disease)			
h. Pernicious Anemia			
i. Primary Biliary Cirrhosis			
j. Other (describe): _____			
9. Acquired Immune Deficiency Syndrome (AIDS) or HIV			
10. Renal transplant, disease and/or impairment			
11. Caisson's disease,barotraumas and/or decompression sickness			
12. Pancreatitis			
13. Diabetes Mellitus			
14. Fungal infections (including, but not limited to, Aspergillis fungus)			
15. Asthma			
16. Blood disorders, dyscrasias or other blood abnormalities			
17. Dislocation of any bones in the jaw			
18. Bone disorders and/or fractures			
19. Herpes Zoster			
20. Any other liver or kidney disease(s) not mentioned above. Please specify: _____			
21. Hypothyroidism or hypoparathyroidism			

G. If you responded "**yes**" to any of the above, please provide the following information for each condition:

Condition	Name and Address of Person(s) Who Diagnosed or Treated Condition	Approximate Onset Date of Condition

H. If you are claiming a psychological or emotional injury in this case, state whether you have ever experienced or have ever been treated for any psychological, psychiatric or emotional problem (including depression) not related to your use of Fosamax.

Yes _____ No _____

If "yes," please provide the following information for each condition:

1. Describe the symptoms experienced. _____
2. Please provide the name, address, telephone number and specialty of the person who provided the diagnosis and/or treatment. _____
3. Please provide the name and address of the facility or hospital, if any, where the treatment was provided. _____
4. For each provider of care identified in subparagraphs 2 and 3, please produce an executed copy of the release form attached as Ex. C, authorizing Merck to obtain your psychotherapy notes and related records generated by any such mental health care practitioner.

I. Have you ever suffered any injury to your head, neck, mouth or jaw?
Yes _____ No _____

If "yes," please state:

1. When the injury occurred. _____
2. The nature of the injury, including what part of the body was injured. _____
3. Please provide the name, address, telephone number and specialty of the person who provided the diagnosis and/or treatment. _____
4. Please provide the name and address of the facility or hospital, if any, where the treatment was provided. _____

5. Please identify the medications taken to treat the injury. _____

VII. CANCER BACKGROUND

A. Have you ever been diagnosed with cancer or metastatic disease?
Yes _____ No _____

If "yes":

1. When were you first diagnosed with cancer or metastatic disease?

2. What type of cancer or metastatic disease was it? _____

3. Who diagnosed this cancer or metastatic disease? (Please provide the name, address, telephone number and specialty of each diagnosing physician). _____

4. Have you been diagnosed with cancer or metastatic disease more than once? Yes _____ No _____

If "yes," provide the information requested in questions 1, 2, and 3 for each cancer or metastatic disease diagnosed. _____

VIII. FOSAMAX AND OTHER BISPHOSPHONATE USE

A. Identify which of the following medications you have taken:

	Yes	No
1. FOSAMAX®		
2. FOSAMAX PLUS D®		
2. Zometa®		
3. Aredia®		
4. Reclast®		
5. Actonel®:		
6. Boniva® or Bondronat®		
7. Didronel®		
8. Skelid®		
9. Nerixia®		
10. Bonefos® or Clastoban® or Clasteon® or Ostac®		
11. Osteolite®		

B. Complete the following information for each drug identified above:

Dates of Use of Drug (month/ day/year)	Dosage and Form of Dose (IV, oral)	Full Name of Physician(s) Who Prescribed	Full Address of Prescribing Physician(s)	Condition(s) Treated	Name of Facility and Street Address of Location Where Drug Was Infused, Injected or Taken or Name and Address of Pharmacy(s) Where Prescription was Filled

C. For what disease or condition were you prescribed each of the medications identified in section VIII(A):

1. Injury, illness, or disability:_____
_____

2. Date(s) of onset:_____
_____

3. Date(s) of diagnosis:_____
_____

4. Please provide the name, address, telephone number and specialty of the person by whom the injury, illness or disability was first diagnosed.
_____
_____

5. List the treatment (surgery, medications taken or prescribed) for the injury, illness or disability._____
_____
_____

D. Did you receive any samples of Fosamax? Yes ____ No ____

If "yes," provide the following:

1. Identify the full name and address of each person who provided them:
_____
_____

2. Identify the approximate date(s) when the samples were provided: ___
_____

E. At the time you first began taking Fosamax or other bisphosphonates did you suffer from any other physical injuries, illnesses or disabilities other than the disease or condition identified in VIII(C) above? Yes _____ No _____

If "yes," identify the injury, illness, or disability, symptoms, date(s) of onset and dates(s) of diagnosis

1. Injury, illness, or disability:_____
_____
_____
2. Symptom(s):_____
_____
3. Date(s) of onset:_____
_____
4. Date(s) of diagnosis:_____
_____
5. Please provide the name, address, telephone number and specialty of the person by whom the injury, illness or disability was first diagnosed. _____
_____

F. To the best of your knowledge, state whether you underwent any of the following tests, procedures, or surgeries BEFORE the injury you allege you suffered occurred.

	Yes	No	Unknown
1. Skeletal bone scan (scintigraphy), Dual Energy X-Ray Absorptiometry (DEXA) scan, or nuclear medicine imaging			
2. MRI (including functional MRI, or MRI spectroscopy), CT or CTA scans for bone			
3. Doppler scans			
4. Ultrasound for bone			
5. PET scans for bone			
6. Interventional radiology procedure images, such as organ procedures or vascular interventional radiology procedures			
7. Vascular surgery			
8. Any other surgery on bone (Please describe: _____)			

G. For each test, procedure, or surgery for which you answered "**yes**," please identify the treating physician and approximate date of the test.

Test/Procedure	Name and Address of Facility Where Test/Procedure Performed	Approximate Dates of Test/Procedure

H. Did you see any written, televised or internet-based advertising or labeling materials regarding Fosamax prior to or during the time you took Fosamax? Yes _____No _____

If "yes," state which written, televised or internet-based advertising or labeling materials you recall seeing regarding Fosamax and when you saw such advertising or labeling materials, excluding any such materials that are covered by the Attorney-Client or Work Product Privileges._____

_____

_____

I. Have you ever visited any website (including any chat rooms) regarding Fosamax or any other bisphosphonates? Yes _____ No _____

If "yes," identify all websites and chat rooms visited that you recall and the approximate dates of visit, excluding any such visits that are covered by the Attorney-Client or Work Product Privileges.

_____

_____

_____

J. Instructions or Information:

1. Did you receive any written or oral instructions or information about Fosamax before you took it? Yes ____ No ____ Don't Recall _____
2. **If "yes,"** please answer the following:
   a. When did you receive the instructions or information?_____
   _____
   b. From whom did you receive it?_____
   c. What written instructions or information did you receive? _____
   _____
   d. What oral instructions or information did you receive? _____
   _____

IX. MONETARY LOSS CLAIMS

A. Have you paid or incurred any medical expenses that are related to any condition that you claim or believe was caused by your use of Fosamax and for which you seek recovery in the action you have filed?

Yes _____ No _____

If "yes," state the total amount of such expenses at this time: $_____

B. Has your insurer, or any other entity or person, paid or incurred any medical expenses that are related to any condition that you claim or believe was caused by your use of Fosamax and for which you seek recovery in the action you have filed?
Yes _____ No _____

If "yes," state the total amount of such expenses at this time: $_____
Please provide an itemized statement of the nature and amount of all damages you are claiming. _____
_____
_____

X. WITNESSES

Please identify all persons (not identified elsewhere in this questionnaire) who you believe possess information concerning your injury, your current medical condition, the medical condition for which you took Fosamax, and/or your claims in this case and for each, state their name, address, telephone number and a description of the information you believe they possess._____
_____
_____
_____
_____
_____

XI. DOCUMENTS AND THINGS

Please indicate whether you or your attorney are in possession of the following documents by checking "Yes" or "No" where indicated and attach copies of the following documents to your response to this profile form. If you withhold a document or information otherwise discoverable by claiming that it is privileged or otherwise protected, you shall make any such claim expressly and describe the nature of the information or document not produced or disclosed in a manner that enables other parties to assess the applicability of the privilege or protection, in accordance with the requirements of Fed.R.Civ.P. 26(b)(5).

A. For each health care practitioner who has examined you, treated you, or consulted with other health care practitioners regarding your medical or dental condition within twelve (12) years of your first use of Fosamax to the present, produce an executed copy of the release form attached to this Plaintiff's Profile Form as Ex. A, authorizing Merck to obtain medical records from each health care practitioner.

B. Produce an additional TEN ORIGINAL SIGNED copies of the release form attached as Ex. A, leaving blank the name to whom the release is directed, authorizing Merck to obtain medical records from each health care practitioner who later becomes known to Merck who has examined you,

treated you, or consulted with other health care practitioners regarding your medical or dental condition at any time.

C. For each hospital, clinic or any other facility at which you have been treated for any medical or dental condition within twelve (12) years of your first use of Fosamax to the present, produce an executed copy of the release form attached as Ex. A, authorizing Merck to obtain medical records from each such hospital, clinic or any other facility.

D. Produce an additional TEN ORIGINAL SIGNED copies of the release form attached as Ex. A, leaving blank the name to whom the release is directed, authorizing Merck to obtain medical records from any hospital, clinic or any other facility that later becomes known to Merck and at which you have been treated for any medical or dental condition at any time.

E. Has any health care practitioner examined you, treated you, or consulted with other health care practitioners regarding your medical, dental or mental condition at or in affiliation with a Veteran's Administration facility? Yes_____ No_____

If your answer is YES, please produce an executed copy of the release form VA 10-5345 attached as Ex. B, authorizing Merck to obtain medical records from each health care practitioner.

F. Has any psychologist, psychiatrist or other mental health care practitioner examined or treated you for any psychological, psychiatric, or emotional injuries, illnesses and/or conditions allegedly suffered as a result of your treatment with Fosamax? Yes_____ No_____

If your answer is YES, please produce an executed copy of the release form Authorization for Release of Mental Health Records attached as Ex. C, authorizing Merck to obtain your mental health records, psychotherapy notes, and clinical information generated by any such mental health care practitioner.

G. A copy of all medical records from any health care provider identified in any of your responses to the questions above. Yes ____ No ____

H. All radiological or other imaging or recordings identified in any of your responses to the questions above. Yes ____ No ____

I. If you have been the claimant or subject of any worker's compensation, Social Security or other disability proceeding, all documents relating to such proceeding. Yes ____ No ____

J. Have you ever made a claim for Social Security benefits, disability insurance benefits, or workers' compensation benefits? Yes_____ No_____

If your answer is YES, please produce an executed copy of each applicable authorization (Form SSA-3288; Authorization for Release of Disability Insurance Records; and/or Authorization for Release of Workers' Compensation Records) attached as Ex. D, authorizing Merck to obtain all documents discussing, describing or memorializing your requests for Social Security, disability insurance, or workers' compensation benefits.

K. If you claim you have suffered a loss of earnings or earning capacity, produce copies of your Federal and State income tax returns and related tax forms (such as W-2s, 1099's, etc.) evidencing all income for each of the years from ten (10) years prior to your injury to the present. Yes ____ No ____

L. Do you claim you have suffered a loss of earnings or earning capacity? Yes_____ No_____

If your answer is YES: please produce executed copies of each of the authorizations (Form 4506 and Authorization for Release of Department of Revenue Records) attached as Ex. E, authorizing Merck to obtain your Federal and State income tax returns for each of the years from ten (10) years prior to your injury to the present.

M. If your answer to Question L is YES, please also produce an executed copy of the authorization Form SSA 7050-F4 attached as Ex. F, authorizing Merck to obtain your earnings information from the Social Security Administration.

N. If you claim you have suffered a loss of earnings or earning capacity, all documents relating to your employment at any time, including documents relating to attendance, leave of absences (whether for vacation, sick leave or other reasons), reported injuries, promotions and demotions, performance evaluations, reports of health examinations, job applications, and wages paid and/or earnings given (including W-2 forms), and all other pertinent documents, including any and all medical, psychological, or testing records or memoranda. Yes ____ No ____

O. If your answer to Question L above is YES, for each of your employers identified in any of your responses to the questions above, please produce two executed copies of the release form Authorization for Release of Employment Records attached as Ex. G, permitting Merck to obtain your employment records, including W-2 forms.

P. Have you ever served in the military? Yes_____No_____

If your answer is YES, please produce an executed copy of Standard Form 180 attached as Ex. H, permitting Merck to obtain your military personnel, service, and health records.

Q. Copies of all documents from any healthcare provider (as defined above) or others discussing, describing, relating to, or memorializing your treatment with Fosamax or to any condition you claim is related to the use of Fosamax. Yes ____ No ____

R. For each insurance company or other organization that has insured you from twelve (12) years prior to your first use of Fosamax to the present, produce an executed copy of the authorization, attached as Ex. I, authorizing Merck to obtain all insurance records from each such company.

S. All documents constituting, concerning or relating to product use instructions,

product warnings, package inserts, handouts or other materials distributed with or provided to you in connection with your use of Fosamax.
Yes ____ No ____

T. Copies of advertisements, written or Internet materials or promotions for Fosamax which you saw prior to or during your use of the medication.
Yes ____ No ____

U. Copies of all websites you visited regarding Fosamax or any other bisphosphonates, your injuries and/or this lawsuit, not including those items covered by the Attorney-Client or Work Product Privileges.
Yes ____ No ____

V. Copies of transcripts of Internet chat room discussions in which you participated regarding Fosamax, any other bisphosphonates, your injuries and/or this lawsuit, not including those items covered by the Attorney-Client or Work Product Privileges. Yes ____ No ____

W. Copies of email relating to Fosamax, any other bisphosphonates, your injuries and/or this lawsuit, not including those items covered by the Attorney-Client or Work Product Privileges. Yes ____ No ____

X. All documents relating to Fosamax or any alleged health risks or hazards related to these drugs in your possession at or before the time of the injury alleged in your Complaint. Yes ____ No ____

Y. All documents you (and not your lawyer) obtained directly or indirectly from Merck. Yes ____ No ____

Z. All diaries, calendars or any other writings or recordings made by you, or by any other person, describing, discussing, explaining or referring to the injuries, damages, or causes of action alleged by you in the Complaint, not including those items covered by the Attorney-Client or Work Product Privileges. Yes ____ No ____

AA. All diaries, calendars or any other writings or recordings made by you, or by any other person, describing, discussing, explaining or referring to the underlying illness or disease for which you received Fosamax, not including those items covered by the Attorney-Client or Work Product Privileges.
Yes ____ No ____

BB. Copies of all documents you (and not your attorneys) obtained from any source related to Fosamax or to the alleged effects of such medications, not including those items covered by the Attorney-Client or work Product Privileges.
Yes ____ No ____

CC. If you claim any loss from medical expenses, copies of all bills from any physician, hospital, pharmacy or other health care provider.
Yes ____ No ____

DD. Decedent's death certificate (if applicable).
Yes ____ No ____ Not applicable ____

XII. LIST OF MEDICAL PROVIDERS AND OTHER SOURCES OF INFORMATION

Identify the following:

A. Your current family and/or primary care physician:

Name	Address	Specialty	Approximate Dates of Treatment

B. Identify each of your *other* primary care physicians for the twelve (12) years prior to the date of your first use of Fosamax or any other bisphosphonate through the present.

Name	Address	Specialty	Approximate Dates of Treatment

C. Each hospital, clinic, or healthcare facility where you have received inpatient treatment or been admitted as a patient during the twelve (12) years prior to the date of your first use of Fosamax or any other bisphosphonate through the present.

Name	Address	Admission Dates	Reason for Admission

D. Each hospital, clinic, or healthcare facility where you have received outpatient treatment (including treatment in an emergency room) during the twelve (12) years prior to the date of your first use of Fosamax or any other bisphosphonate through the present.

Name	Address	Treatment Dates	Reason for Treatment

E. Identify each health care provider who has ever seen or treated you for osteoporosis or the underlying illness for which you took Fosamax.

Name	Address	Specialty	Approximate Dates of Treatment

F. Each dentist, orthodontist, periodontist, oral and maxillofacial surgeons or other healthcare provider involved in providing dental care or treatment who you have ever seen or from whom you have ever received treatment.

Name	Address	Specialty	Approximate Dates of Treatment

G. Identify any other healthcare provider by whom you have been seen or from whom you have received treatment for any reason during the twelve (12) years prior to the date of your first use of Fosamax or any other bisphosphonate through the present.

Name	Address	Specialty	Approximate Dates of Treatment

H. If you are claiming any psychological or emotional damages, identify each psychiatrist, psychologist, mental health counselor, therapist and/or social worker from whom you have received treatment or with whom you have consulted regarding your health during the twelve (12) years prior to the date of your first use of Fosamax or any other bisphosphonate through the present.

Name	Address	Specialty	Approximate Dates of Treatment

I. Each pharmacy that has dispensed medication to you in the twelve (12) years prior to the date of your first use of Fosamax or any other bisphosphonate through the present.

Name	Address

DECLARATION

I declare under penalty of perjury that all of the information provided in this Plaintiff Profile Form is true and correct to the best of my knowledge, I have supplied all the documents requested in part XI of this Profile Form to the extent that such documents are in my possession, custody, or control, or in the possession, custody, or control of my lawyers, and I have supplied the authorizations attached to this declaration.

Signature	Print Name	Date

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